MICHIGAN
Primary Care
ASSOCIATION

Testimony by Douglas M. Paterson MPA
Director of State Policy
Michigan Primary Care Association

Before the House Health Policy Committee
Representative Gail Haines, Chair
January 19, 2012

Good morning Madam Chair and members of the committee. My name is Doug Paterson and I am here today representing the 32 community health center organizations in Michigan (also called Federally Qualified Health Centers or FQHCs). These organizations operate 185 community owned and operated delivery sites across Michigan, providing comprehensive medical and dental services to nearly 600,000 Michigan residents. These organizations form an essential component of the State's safety net and are on the front lines of Michigan's health care delivery system. They serve the most vulnerable populations in Michigan's rural and urban communities. All of the Health Centers are located in medically underserved areas or serve medically underserved populations. In fact, three out of four (3/4) of the Michigan residents our Health Centers serve are either uninsured or on Medicaid.

The MiHealth Marketplace is of particular interest to the Community Health Center network because so many of the people we treat are uninsured and will benefit from an insurance exchange in Michigan. A major portion of these patients have jobs, but their employers do not provide health insurance benefits or don't offer benefits at a price they can afford. We believe implementation of the MI Health Marketplace in Michigan will allow market forces to work more effectively by creating competition among insurers and providers, spreading risk among the pool of people to be insured, and helping to mitigate against increasing premiums. We are before you today because we believe it is imperative to pass authorizing legislation immediately that will begin to create the structure in Michigan through which purchase of insurance for individuals and small businesses can be better organized.

We have four compelling reasons for our request:

1) A Health Insurance Exchange is a good idea even if the ACA is found unconstitutional next June. Delaying until then has no purpose if this premise is accepted. To substantiate this belief, I would direct you to a paper which have attached to this testimony written by the Heritage Foundation in 2006, two years before President Obama's election, that concludes:

> State-level health insurance exchanges would increase health insurance coverage, significantly lower prices in the individual coverage market, give individuals and families access to more choice,

allow coverage portability, and increase employer's flexibility in offering health benefits.

2) According to a memo dated October 4, 2011to Governor Snyder from Steve Hilfinger, Director of the Department of Licensing and Regulatory Affairs:

   Unless Michigan is prepared to implement an exchange by June 30, 2012, our state will be ineligible for federal funding to design and operate an exchange.

   Without such funding, our state will likely abdicate responsibility for design and operation of the exchange to the federal government. This could mean that the feds will likely be dictating eligibility and information systems requirements, which could have sizeable impact on Michigan processes and current IT systems. It also means jobs that would be created to operate the exchange in Michigan will likely be created elsewhere.

3) The memo also states that the federal government must certify by January 1, 2013, just one year from now, that Michigan is capable and ready to operate a state exchange.

   The Information Technology requirements to implement the exchange will be massive.
   It just took the state's Medicaid program four (4) years to implement its new information management system (CHAMPS). To successfully implement a more expansive effort in just 12 months will be next to impossible if we don't begin immediately. Important decisions need to be made now in Michigan to have the exchange be effective for our State.

4) While many have advised you to "go slow", the slower we go in getting the structure and decision making authority in place, the less time we will have to actually design the exchange. It seems prudent to get the structure in place and identify the people who will be making important decisions to allow sufficient time for dialogue, research and design to get it as right as possible. Members of this committee, as well as you Chairwoman Haines have stated several times that getting it right is most important. If we delay, we will have to do the heavy lifting in a much shorter amount of time, which in our opinion is much more likely to lead to mistakes.

We believe legislation creating a Michigan exchange is needed now so that planning efforts can begin as soon as possible.

Thank you for listening to our concerns!

WebMemo
Published by The Heritage Foundation
No. 1230
October 5, 2006

The Rationale for a Statewide Health Insurance Exchange

Robert E. Moffit, Ph.D.

U.S. health insurance markets are governed by a complex system of state and federal laws and regulations, many of which are outdated and counterproductive. The most important of these laws is the federal tax code. Americans get unlimited federal tax breaks for the purchase of health insurance if they receive that coverage through their workplace. Outside of the workplace, however, they almost always pay for coverage with after-tax dollars. Statewide health insurance exchanges are a solution to this inefficient inconsistency, giving individuals and families the opportunity to secure the health plans of their choice without losing tax benefits.

The Federal Tax Code

The federal tax code profoundly distorts health insurance markets. By law, Congress ties the enormous tax benefits of health insurance almost exclusively to the place of work. Workers who buy health coverage outside of the employer-based system often have to cope not only with high administrative costs and inflexible government mandates, but also with the loss of federal and state tax breaks. The loss of these tax breaks could add 40 to 50 percent to the cost of a policy purchased through the place of work.

Employers do not own auto, life, homeowners', or property and casualty insurance policies on behalf of their employees. Indeed, most Americans would find such arrangements strange. But in contrast to every other type of insurance in the private market, health insurance in the United States sticks to the job, not the person. Employers own health insurance policies; individuals and families do not.

The current tax law also directly affects coverage. Recent empirical data shows that among the total number of the uninsured, the proportion of long-term uninsured is small—only slightly more than one out of ten over a four-year period. The overwhelming majority of the uninsured are in and out of coverage, usually due to changes in their job situation. They had access to insurance but lost it. Without personal ownership of health insurance policies, there is not any real portability in coverage. The problem is not simply access to health insurance coverage; it is also keeping that coverage. The right policy, then, would have health insurance stick to the person, not the job.

Congressional Inaction

Congress could simply change the federal tax code to give individuals and families tax relief for the purchase of health insurance regardless of where they work so that they can buy and own the coverage they want at competitive prices. In other words, by changing the tax code, Congress could take a dramatic step to creating a real, consumer-driven health insurance market. Going even further, if Congress allowed interstate commerce in health insurance—letting individuals and families

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/wm1230.cfm

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214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

to buy coverage across state lines from any state in the United States—it would create a single national market for insurance coverage. In this large market, with large health insurance pools, individuals and families would own and control their own health insurance. These reforms would create a robust system of consumer choice and competition.

Enter the State Health Insurance Exchange

Short of congressional action to reform the tax code, the burden to improve health coverage rests with state officials. The best way to enable individuals and families to buy, own, and keep health insurance from job to job—without losing the tax advantages of the employment-based coverage—is to transform the balkanized and dysfunctional state health insurance market into a single health insurance market. This new market would function well for all sorts of individuals and small businesses, not just workers employed by large companies.

A sound legal framework is necessary to secure fully functioning and efficient markets. Current law governing health insurance in many states does not work well to control costs or to expand personal access to coverage. Accordingly, state officials who are serious about creating new, consumer-based systems need to create a new legal framework for health insurance.

The best option is a health insurance market exchange. A properly designed health insurance exchange would function as a single market for all kinds of health insurance plans, including traditional insurance plans, health maintenance organizations, health savings accounts, and other new coverage options that might emerge in response to consumer demand. In principle, it would function like a stock exchange, which is a single market for all varieties of stocks and reduces the costs of buying, selling, and trading stocks. For the same reasons, other types of market transactions are also centralized, such as farmers' markets, single locations where shoppers can purchase a variety of fresh fruits and vegetables, and Carmax, where consumers can choose from among all kinds of makes and models of automobiles.

In the case of a statewide health insurance exchange, employers would designate the health insurance exchange itself as their "plan" for the purpose of the federal and state tax codes. Thus all defined contributions would be tax free, just as they would be for conventional employer-based health insurance. The major benefits of this arrangement for employers, particularly small employers, are a reduction in administrative costs and paperwork and the ability to make defined contributions to their employees' preferred plans.

As a vehicle for a defined-contribution approach to health care financing, an exchange would expand coverage and choice. Rather than have to decide whether to pay for full coverage or not, employers could make defined contributions of any size to the exchange. Moreover, employers could also enable employees, including those working part-time and on contract, to buy health insurance with pre-tax dollars. Under a Section 125 plan, any premium payments made by workers, even part-time workers or contract employees, would be 100 percent tax-free. This is especially important for workers in firms that require them to pay part of the health insurance premium. Employees, not employers, would buy the health care coverage with *pre-tax* dollars, would own their own health plans, and would take them from job to job without the loss of the generous tax benefits of conventional employer-based coverage. This is a revolutionary change in the health insurance market.

Unlike other state-based initiatives, the creation of a statewide health insurance exchange would not violate the Employee Retirement Income Security Act of 1974 (ERISA). This approach complies with ERISA because employer participation in an exchange is *voluntary*—though, given the benefits of an exchange, few small businesses would turn down the option. An exchange can be designed within the existing framework of other federal insurance laws, including the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act (HIPAA).

Limited Functions

A health insurance exchange could be the basis of a new legal framework for health insurance at

the state level. It could replace much of the existing state law, which creates separate individual and small group markets and governs balkanized and overregulated state health insurance markets. Ideally, an exchange should be open to all state residents and all interested employers, regardless of the size of the firm, who want to arrange health insurance through the exchange.

The specific functions of an exchange would be mechanical, not regulatory. An exchange should not license or standardize health plans or impose underwriting rules or benefit mandates. The focus should be on processing paperwork—mostly processing employer and employee contributions or independent premium payments—and administering enrollment and coverage selection through an annual open season. It should function just like the human resources department of a very large employer. An exchange could also be a mechanism for the administration of government subsidies for low-income persons, if state officials wanted to extend that help. Similarly, it could be a mechanism for the administration of federal health care tax credits for individuals and families, if Congress should ever decide to enact individual tax relief for health care and help individuals and families without employer-based coverage.

An exchange should be administered by a nongovernmental entity operating under a special state government charter. Irrespective of the organizational structure, the functions of an exchange could be contracted out to private entities or private third-party administrators. From the perspective of health policy, the issue of governance is of secondary importance.

Conclusion

State-level health insurance exchanges would increase health insurance coverage, significantly lower prices in the individual coverage market, give individuals and families access to more choice, allow coverage portability, and increase employers' flexibility in offering health benefits.

Congress should reform the tax treatment of health insurance. But short of congressional action to rectify the inequities of the federal tax code, a health insurance exchange is the best way for individuals and families to secure personal and portable health insurance without incurring heavy tax penalties.

Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation.

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

STEVEN H. HILFINGER
DIRECTOR

Memorandum

DATE: 10/4/2011

TO: Governor Rick Snyder
Dennis Muchmore
Dick Posthumus
John Roberts

FROM: Steve Hilfinger, Director, Licensing and Regulatory Affairs
Chris Priest, MIHealth Marketplace Project Manager

CC: Shelly Edgerton, Deputy Director, LARA
Lisa Gigliotti, General Counsel, MIHealth Marketplace

SUBJECT: MIHealth Marketplace Timelines and Deadlines

As you know, following the Governor's special message on health, there has been debate around the need to pass Exchange legislation by this Thanksgiving. There are some who believe that Michigan can wait until the summer of 2012. This memo is intended to provide you with timelines mandated by federal law and regulations, as well as to show the operational challenges of further delay. It supports why we must act now to put together an Exchange in a way that would prevent a federal Exchange from being forced upon the State.

Timelines

9/30/11: MI submitted a Level 1 grant application -- roughly $9.849m for contractual services, additional data analysis and staffing needs (grant awarded 45 days after submission)
12/30/11: Last date to apply for Level 1 grant funding and next opportunity to apply for Level 2 grant funds (grants awarded 45 days later)
3/30/12: Next opportunity to apply for Level 2 federal funding (grant awarded 45 days later)
6/29/12: Last date to apply for Level 2 federal funding (grants awarded 45 days later)
Summer/Fall 2012: HHS will begin Exchange certification process
1/1/13: HHS must certify the State will be ready to "Go Live" on 1/1/14
Spring 2013: System testing with the federal government and other interfaces to commence
10/1/13: Open Enrollment begins (i.e. "Go Live")
1/1/14: Tax Benefits start flowing to individuals and small businesses

The Case for Immediate Action

Operational

- This is one of the most complex IT initiatives Michigan has ever had to undertake. Without legislation setting the framework for an Exchange, very limited IT work – from either the State, private sector or the MIHealth Marketplace – can be done and federal timelines are already very tight. If Michigan waits until the final deadline (6/29/12) to secure funding to establish the Exchange, there is very little chance Michigan will be able to be certified by the federal government and a federal "one size" Exchange will be implemented in Michigan.
- The MIHealth Marketplace is required to coordinate with the federal government, insurance carriers (many of whom may have to update their legacy systems to coordinate with the Exchange), Medicaid, Human Service programs, local providers, businesses, etc. Without knowing the IT systems the Exchange will be procuring, the State and the private sector may not be able to make the changes necessary in time to avoid a federal takeover of the Exchange, and the cost for these changes will not be as controllable by Michigan (government and/or the private sector). This will lead to higher costs for taxpayers, consumers and businesses.
- If legislation is not adopted this year, the State will need to enter into discussions early next year with the federal government about implementing a federal Exchange. Operationally, especially for state agencies, Michigan will need to begin to change our systems next year in order for that function to be operational under the current federal timelines. All of this will distract attention from our Michigan Exchange planning.

Legal

- The federal government, as a part of the grant process, will obligate funds to Michigan to pay for the cost of a health insurance Exchange – 100% federal match, except for 10% of the cost to change Medicaid IT systems. Early deployment and commitment of grant funding is beneficial. If grant is revoked, only unencumbered (uncommitted) funds likely would have to be returned.
- The ACA litigation brought by the States basically concerns two matters: 1) the individual mandate and 2) the expansion of Medicaid. No court has found that the Medicaid expansion is unconstitutional. One district court found that the entire law was unconstitutional, but the appellate court disagreed saying that only the individual mandate was unconstitutional. Some legal experts agree that if anything were to be thrown out by the Supreme Court it would be the individual mandate, not the Exchange sections of the law – meaning that Michigan would need to comply with those provisions anyway.

Financial Impacts

- Acting now would give Michigan time and flexibility to ensure a fiscally prudent approach to the MIHealth Marketplace, and give more certainty (in terms of costs) to the private sector. Deferring to the federal government or not acting swiftly will only increase uncertainty, which leads to higher risk in the insurance marketplace, and higher health care costs for Michigan consumers and job providers.
- If Michigan waits to implement an Exchange, then other states who are acting will procure services from the vendors who are currently working on Exchange-related business. This means that Michigan (i.e. the State, the Exchange and the private sector) will pay more for the same services that other states and their businesses are receiving

because there is less time to meet federal deadlines since vendors' services would already be utilized elsewhere, forcing them to increase costs to meet their obligations.

- Financing from the federal government can only be applied for once a quarter, meaning we have only 3 more opportunities to apply for federal financing. It takes (at a minimum) a month to put together any federal grant application. Funds are then allocated 45 days after the grant is submitted. If we wait until the last opportunity to receive funding, Michigan will not see that award until mid-August 2012, which gives the Exchange 14 months to "Go Live." To put this in perspective, it took 4 years to upgrade the Medicaid claims payment system (CHAMPS) and this project is more complex and could involve possible changes in the private sector's IT systems as well.
- Some of the decisions required to receive federal funding (e.g. a governance structure, a 4 year budget, etc) will be subject to legislative approval and decisions by the board of directors of the MIHealth Marketplace. Without adequate time to make critical decisions (e.g. business operations, public policy that impacts carriers inside and outside of the Exchange, set up a governance structure, etc), we increase the likelihood that a federal Exchange will be imposed on Michigan.

Risks Associated with Waiting

- The longer Michigan waits to implement an Exchange, the greater the risk that any action Michigan takes will be preempted by the federal government. This means we would deny the right of Michiganders to decide what's best for Michigan.
- If the federal government does not certify Michigan on 1/1/13 (i.e. one year and 3 months from now), Michigan could lose some control over its insurance markets – since the federal Exchange could become an active purchaser of health care and decrease choice in the marketplace. It is possible that the federal Exchange could also take over, duplicate or change, some functions of OFIR.
- The State budget would likely incur significant expenditures as a result of a federal Exchange, leaving State government (both Executive and Legislative branches) unable to control costs mandated by the federal government. The Medicaid program is required to coordinate with the Exchange. A federal Exchange will dictate system changes we need to make, as well as control some aspects of eligibility policy, since the Exchange has to do eligibility determinations for those in the Medicaid program that come to it looking for health care. In any event, it is highly probable that a federal Exchange will have an impact on budgets for DTMB, LARA/OFIR, DCH, and DHS, and Michigan may have little control over those costs.
- Michigan would have no ability to minimize the cost of the Exchange on Michigan job providers, as the federal government has indicated it will charge insurance carriers fees for the cost of the federal Exchange and there is no indication of what they will charge or who will be making those decisions.

Michigan Level I Grant Application
CFDA: 93.525

Cooperative Agreement to Support Establishment of the "MIHealth Marketplace" Michigan Department of Licensing and Regulatory Affairs

On September 14, 2011, Governor Snyder announced Michigan's intention to implement a state-established Health Insurance Exchange, known as "MIHealth Marketplace." This entity will be established as a new, non-profit corporation in Michigan, governed by a board of directors and with an Executive Director handling the day-to-day operations of the Exchange.

Governor Snyder has also appointed the Michigan Department of Licensing and Regulatory Affairs (LARA) to lead the planning and establishment of the MIHealth Marketplace in Michigan because of its proximity to state insurance market oversight and regulation, while continuing to work closely with the Michigan Departments of Community Health, Human Services, Technology Management and Budget, as well as other state agencies and stakeholders.

The Michigan Department of Licensing and Regulatory Affairs (LARA) is applying for $9,849,305 in Level I funding for the Cooperative Agreement to Support Establishment of a State-Operated Health Benefit Exchange. These resources will be used to expand upon the State's planning activities related to the design, development and implementation of a state-based Health Benefit Exchange. More specifically funding will be used to:

1. Conduct additional analysis on the impacts of the MIHealth Marketplace and the Affordable Care Act (ACA) in Michigan, including additional insurance market analysis.
2. Utilize contractual services to assist the State and the MIHealth Marketplace with legal matters, technology planning, education and outreach, financing and policy issues.
3. Support initial start up costs for the non-profit corporation after legal authority to create the Exchange is established in Michigan.
4. Hire staff for the MIHealth Marketplace, after legal authority to create the Exchange is established in Michigan, and support the State of Michigan as it works toward establishment of this new entity.

Michigan estimates that at least 520,000 individuals and small businesses will be assisted through the Exchange, with an additional 500,000 Michiganders coming though the Exchange and being found eligible for Medicaid.